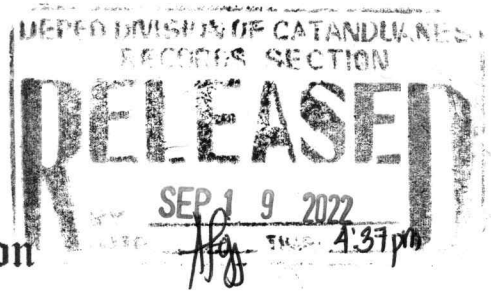




Republic of the Philippines  
Department of Education  
REGION V - BICOL

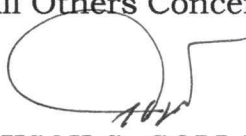
SCHOOLS DIVISION OFFICE OF CATANDUANES



**UNNUMBERED MEMORANDUM:**

OSDS-PER-UM-09-19-2022/MBL

TO : Assistant Schools Division Superintendent  
Chief Education Supervisors  
Public School District Supervisors  
Elementary and Secondary School Heads  
All Others Concerned

FROM :   
**SUSAN S. COLLANO**  
Schools Division Superintendent

SUBJECT : **REGISTRATION FOR PHILHEALTH KONSULTA  
BENEFIT PACKAGE**

DATE : September 19, 2022

1. In view of the letter received by this Office from Philippine Health Insurance Corporation, Catanduanes Local Health Insurance Office (LHIO) re: **PhilHealth Konsulta Benefit Package** which may be availed of by PhilHealth members and their declared legal dependents in their accredited facility of choice, all employees are advised to register via PhilHealth Member Portal which can be accessed at **www.philhealth.gov.ph** or through PhilHealth LHIO located at Virac Town Center.
2. Attached is the Philhealth Konsulta Registration Form (PKRF).
3. For information, guidance and strict compliance.

MBL/UM-Registration for Philhealth Konsulta Benefit Package  
005/September 19, 2022



San Roque, Virac, Catanduanes  
(052) 811-40-63  
catanduanes@deped.gov.ph  
www.depedrovcatanduanes.com  
DepEd Tayo-Region V - Catanduanes



### PhilHealth KonSulTa Registration Form



To be filled-out by MEMBER/Dependent Beneficiary

NAME (Last, First, Middle): \_\_\_\_\_

PIN: \_\_\_\_\_ Birthdate(mm/dd/yyyy): \_\_\_\_\_

Home Address: \_\_\_\_\_

And to include my DEPENDENTS (if applicable)

PIN	Name of Dependents	Date of Birth (mm/dd/yyyy)

Preferred KonSulTa Facility: 1<sup>st</sup> Choice: \_\_\_\_\_  
2<sup>nd</sup> Choice: \_\_\_\_\_ 3<sup>rd</sup> Choice: \_\_\_\_\_

\_\_\_\_\_  
(Printed Name & Signature of Member/Depndent)

PhilHealth's Copy

cut-----cut



### PhilHealth Konsulta Registration Confirmation Slip



To be filled-out by Authorized PhilHealth Personnel

Registration No.: \_\_\_\_\_

Date Registered: \_\_\_\_\_

Name: \_\_\_\_\_

PIN: \_\_\_\_\_

PhilHealth Konsulta Facility: \_\_\_\_\_

Konsulta Facility Address: \_\_\_\_\_

\_\_\_\_\_  
(Printed Name & Signature of Authorized Personnel)

Beneficiary's Copy



### PhilHealth KonSulTa Registration Form



To be filled-out by MEMBER/Dependent Beneficiary

NAME (Last, First, Middle): \_\_\_\_\_

PIN: \_\_\_\_\_ Birthdate(mm/dd/yyyy): \_\_\_\_\_

Home Address: \_\_\_\_\_

And to include my DEPENDENTS (if applicable)

PIN	Name of Dependents	Date of Birth (mm/dd/yyyy)

Preferred KonSulTa Facility: 1<sup>st</sup> Choice: \_\_\_\_\_  
2<sup>nd</sup> Choice: \_\_\_\_\_ 3<sup>rd</sup> Choice: \_\_\_\_\_

\_\_\_\_\_  
(Printed Name & Signature of Member/Dependent)

PhilHealth's Copy

cut-----cut



### PhilHealth Konsulta Registration Confirmation Slip



To be filled-out by Authorized PhilHealth Personnel

Registration No.: \_\_\_\_\_

Date Registered: \_\_\_\_\_

Name: \_\_\_\_\_

PIN: \_\_\_\_\_

PhilHealth Konsulta Facility: \_\_\_\_\_

Konsulta Facility Address: \_\_\_\_\_

\_\_\_\_\_  
(Printed Name & Signature of Authorized Personnel)

Beneficiary's Copy

PhilHealth KonSulTa Registration Form

**Additional Dependents** *(if applicable)*

PIN	Name of Dependents	Date of Birth (mm/dd/yyyy)

INSTRUCTIONS

1. All information must be written in UPPER CASE/CAPITAL LETTERS
2. All fields are mandatory.
3. If BENEFICIARY is DEPENDENT, please use the **dependent's PhilHealth Identification Number (PIN)**.
4. If beneficiary is below 21 years of age, the signatory must be the parent/guardian.
5. If the BENEFICIARY is DEPENDENT ONLY, please write name in the space provided for the dependents.

PhilHealth KonSulTa Registration Form

**Additional Dependents** *(if applicable)*

PIN	Name of Dependents	Date of Birth (mm/dd/yyyy)

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